STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Nursing and Rehabilitation Center	235 Dolphin Ave Northfield, NJ 08225

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #: NJ186394 Based on interviews, review of the medical records, and other facility documentation, it was determined that the facility failed to ensure staff provided safe transfers with a two person assist from chair to bed when on 05/08/2025, a Certified Nursing Aide (CNA #1) transferred a resident (Resident #1) with a Hoyer lift (mechanical lift used to transfer) with no additional staff, and the resident complained of pain with noted bruising to the inner thigh and a swollen knee, that an x-ray identified that the resident sustained a fracture of the distal femoral shaft (thigh bone). This deficient practice was identified for 1 of 3 residents reviewed for accidents and hazards (Resident #1), and was evidenced by the following: A review of an incident report for Bruise dated 05/09/2025 at 5:30 AM, revealed that around 5:30 AM, the assigned CNA reported to this supervisor that she found bruises on the resident's right leg. Upon assessment, the resident was seen with a bruise measuring nine centimeters by four centimeters (9 cm x 4 cm) on the back of their right lower leg, and an additional bruise on their right inner thigh measuring 7 cm x 4. 5 cm. The resident was also noted with swelling and pain to their right knee. The report also included on 5/10/25, that staff spoke to the hospital and the resident was admitted with a fracture of the right femur . Documented on 5/18/25, that on 5/15/25, the resident still remained in the hospital and after multiple questioning sessions, CNA #1 admitted to not having assistance with the Hoyer lift transfer when transferring the resident from the geriatric (geri) chair (specialized chair for people with limited range of motion) to bed on 05/08/2025, which was against facility policy. On 05/22/2025 at 10:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about Resident #1's incident report. The LNHA stated that the facility could not prove that CNA #1 broke Resident #1's leg, but CNA #1 did not follow the facility's policy and procedure. According to the LNHA, CNA #1 was dishonest during the investigation, and CNA #1 stated they had another aide (CNA #2) assist her with the use of Hoyer lift which CNA #2 denied. According to the admission Record face sheet (an admission summary), Resident #1 was admitted to the facility with diagnoses which included but were not limited to; contracture of muscle, bipolar disorder, dementia and pseudobulbar affect (a neurological condition characterized by uncontrollable episodes of laughing or crying). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to the Minimum Data Set (MDS), an assessment tool dated 02/25/2025, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident's cognition was severely impaired. The MDS also indicated that Resident #1 required total care with all activities of daily living (ADLs) and was dependent with locomotion on and off the unit. A review of Resident #1's individualized comprehensive care plan (ICCP) included a focus area dated 06/24/2019, and revised on 05/11/2025, that the resident cannot do things by themselves anymore. The goals included that the resident would continue with physical therapy through the next review date. Interventions included: to transfer with the use of Hoyer lift only with two staff assistance for transfer and nursing restorative for passive range of motion to cervical/neck and bilateral lower extremities (BLE). On 06/05/2025 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) and the LNHA, who stated that on 05/08/2025 at 8:20 PM, the CNA #1 stated that they observed swelling to the resident's right knee while transferring Resident #1 from the geri chair to bed with the use of a Hoyer lift and Resident #1 had pain. CNA #1 further stated that Resident #1 verbalized and expressed pain by moaning during the transfer and they notified the License Practical Nurse (LPN #1), who assessed Resident #1, and medicated Resident #1 with Tylenol 325 milligrams for pain. The DON continued that LPN #1 notified the supervisor who did a change in condition and notified the physician (via a non-emergency fax was sent to physician). At 10:50 PM, the physician did not return the call. According to the LNHA, the facility's policy was if the physician did not respond, the staff should call a second time, and if no response, the Medical Director should be called. At that time, the DON and LNHA stated that on 05/09/2025 at 5:30 AM, CNA #2 reported to the supervisor that Resident #1's right knee had swelling, was painful to touch, and ecchymosis (bruise with skin discoloration). A review of the Progress Notes included a Plan of Care Note dated 05/09/2025 at 5:54 AM, authored by the Registered Nurse (RN) Supervisor, that they assessed the resident and found bruises on the back of their lower right leg that measured 9 cm x 4 cm, and another bruise on their right inner thigh that measured 7 cm x 4.5 cm. The RN Supervisor documented that at 5:50 AM, LPN #2 provided the resident Tylenol with relief. The RN Supervisor called the family and physician with no response and a message was left. A review of the Progress Notes included a Health Status Note dated 05/09/2025 at 8:29 AM, that LPN #3 documented Resident #1's right lower extremity was bent with their knee swollen and noted bruises. The physician was notified, and a stat (immediate) order was obtained for an x-ray. A review of the Radiology Result Report dated 05/09/2025 at 2:21 PM, indicated: Fracture of the distal femoral shaft with malalignment (a break in the lower part of the thigh bone). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/06/2025 at 12:11 PM, the surveyor interviewed CNA #2, who stated she received the report from CNA #1 that Resident #1's knee was swollen (unable to recall which knee) and to monitor the resident. CNA #2 further stated she went into the resident's room and observed swelling to their knee (unable to recall which knee) and left the room to finish her rounds. CNA #2 further stated that at 3:00 AM, she observed the resident sleeping and then at 5:30 AM, she went in the resident's room for incontinent rounds, and she observed bruising to the inner thigh (unable to recall which leg) that was painful to touch. CNA #2 stated the supervisor was made aware. The surveyor asked CNA #2 what the facility's policy for Hoyer lift transfers was, and CNA #2 stated a Hoyer lift was used to minimize the risk for a fall or injury to a resident. CNA #2 stated a Hoyer lift was used with two people, either nurses or aides, and one person guided, and the other person steered the Hoyer lift. On 05/06/2025 at 1:31 PM, the surveyor interviewed LPN #3, who stated they received a report from CNA #2 at approximately 6:50 AM, that [Resident #1's] leg was broken. LPN #3 stated she observed the back of Resident #1's right knee was swollen with bruising on their right inner thigh and discoloration. LPN #3 stated she notified the physician for a stat x-ray that was done at 1:16 PM, with the results were read at 2:27 PM, and the resident was sent to the hospital at 2:42 PM. On 05/06/2025 at 1:42 PM, the surveyor called the following facility staff to conduct interviews: the RN Supervisor, CNA #1, LPN #1, and the physician. The surveyor received no response or call back. On 06/05/2025 at 2:00 PM, the surveyor conducted a telephone interview with LPN #2, who stated she received a report from LPN #1 that Resident #1's right knee was swollen and the supervisor was aware. LPN #2 stated at 5:30 AM on 05/09/2025, CNA #2 informed the supervisor of resident's right leg bruising. On 06/05/2025 at 3:30 PM, the surveyor interviewed the Unit Manager (UM), who stated on 05/09/2025 at 6:50 AM, she received a report from the supervisor that Resident #1 had a bruise on their right leg and was observed with a swollen right knee, bruise to their inner thigh, the physician was notified by LPN #3, and an x-ray was ordered. The resident was transferred to the hospital after the results were read. On 06/05/2025 at 4:00 PM, the surveyor interviewed the LNHA, who stated the investigation regarding the incident revealed CNA #1 provided multiple names of staff that assisted her with the Hoyer lift transfer. The LNHA stated it was discovered during ongoing investigation that CNA #1 admitted to transferring Resident #1 with the Hoyer lift by herself. A review of the facility investigation statements on 05/15/2025 at 11:49 AM, revealed that the DON documented a second phone interview with CNA #1 in the presence of the LNHA was conducted. The DON asked CNA #1 if they used the Hoyer lift by herself to transfer Resident #1 to bed, and CNA #1 confirmed yes, I put [the resident] in bed by myself. The DON documented that she informed CNA #1, this is important information because in your last statement you did not mention that you transferred [the resident] by yourself with the Hoyer lift. And this is against our policy. You know there must be 2 people to operate the Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy titled Change in a Resident's Condition or Status. Under: Procedure revealed: The nurse will notify the resident's Attending Physician On-call when there has been a (an): discovery of injuries of an unknown source. 2. Notify the resident's Attending Physician or Physician On-Call to report Changes in a Resident's Condition (CIC). A. If no response from Physician after 20 minutes, a second attempt will be made by nursing; B. The Supervisor of Nursing is to be contacted if there is lack of response from Physician; and C. If no response received from the Attending Physician, the Supervisor of Nursing will notify the Medical Director regarding Changes in a Resident's Condition (CIC) and lack of response from resident's Attending Physician . A review of the facility's Lift (Hoyer, Mechanical Lifter) policy included under policy: It is the policy of the facility that two (2) persons must be used for a lifting, preparation, including transferring to and from one surface to another . NJAC 8:39-27.1 (a)